YOU MAY WRITE ONE CHECK PER FAMILY – PAYABLE TO MIDDLESEX REC. DEPT.

MAIL IN OR DROP OFF REGISTRATION FORM AT RECREATION OFFICE

1200 MOUNTAIN AVENUE, MIDDLESEX, NJ 08846 • (732) 356-7400 X277 • recreation@middlesexboro-nj.gov

***** PLEASE CHECK APPROPRIATE ACTIVITY! *****

_____BASKETBALL (Grades 3-8 - $55)

Teams are divided by gender and are split into the following divisions: 3rd&4th grade, 5th&6th grade and 7th&8th grade. Most games are held on Saturday's but may be other night(s) depending on registration numbers. Teams may play in a recreation based inter-town league with home & away games. All practices are once per week at the coach's discretion. Middlesex residents only.

_____WRESTLING (Grades K-6 - $30)

Practices are held on Monday's, Wednesday's and Thursday's in the High School Wrestling Room. Meets are weekdays and/or weekends. Some tournaments may have an additional fee. Middlesex and Dunellen residents are eligible.

DO NOT WRITE IN BOX (*for office use **only***)

$55 Reg. Fee Pd. _____ $30 Reg Fee Pd. _____

Receipt #_____ $10 Late Fee Pd ____

Date Rcv'd_____

DEADLINE TO REGISTER IS OCTOBER 28, 2016

No late registrations will be accepted. A waitlist will be started after the deadline.

FILL OUT ONE FORM PER ACTIVITY, PER CHILD • NO REFUNDS AFTER NOV. 23, 2016 FOR BASKETBALL AND DEC. 16, 2016 FOR WRESTLING. ALL PRIOR REFUNDS ARE LESS 10% ADMIN FEE.

NAME (*print CLEARLY*)_____ GRADE_____ BOY_____ GIRL_____

ADDRESS_____ CONTACT PHONE ( )_____ - _____

BIRTHDATE_____/_____/_____ SCHOOL_____ **Wrestling only** - WEIGHT _____lbs.

_____ **I WOULD BE INTERESTED IN VOLUNTEERING THIS YEAR**. Name _____

If yes - daytime phone number to reach you ( )_____-_____ Volunteer Coaches Shirt Size _____

EMERGENCY TREATMENT RELEASE

Dates during which release is granted – FROM: November 1, 2016 TO March 31, 2017

TO WHOM IT MAY CONCERN: As a parent and/or guardian of _____, a minor, I herewith authorize the treatment by a qualified and licensed medical doctor in the event of a medical emergency which, in the opinion of the attending physician, may endanger his or her life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

Parent (s)/Guardian Info:

_____ _____Ph # _____ Cell #_____

Parent Name address (if different than above)

_____ _____Ph # _____Cell #_____

Parent Name address (if different than above)

Contact e-mail _____

Other contact in case of emergency (DO NOT USE YOURSELF): Name _____

Phone_____ H / W / C Relationship to child_____ Hospital Preference_____

Specific medical allergies, chronic illness or other medical conditions the staff should be aware of:_____

_____

This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence. I confirm that my child is up to date on all immunizations as required by the NJ Dept. of Health and Senior Services Annual Immunizations Report. I also agree that all the information provided is correct and factual. If information is found to be false, I understand that my child will be expelled from the program without reimbursement of fees paid. I also have received the spectator guidelines.

Parent/Guardian Signature_____ **Date:**_____